

11
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11878 CERTIFICATE OF DEATH

11857

Reg. Dist. No. 331

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <i>Salisbury</i>		LENGTH OF STAY (In this place) <i>5 days</i>		CITY (If outside corporate limits, write RURAL end give nearest town) <i>Snow Hill</i>		238-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>ALONZO</i>				(First) (Middle) (Last) <i>AKURS</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>November 25 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>1892</i>	9. AGE last birthday <i>64</i> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Quality Plant</i>		11. BIRTHPLACE (State or foreign country) <i>Alabama</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or ink.) <i>No</i>		16. SOCIAL SECURITY NO. <i>251-03-2144</i>		17. INFORMANT & ADDRESS <i>Mr. Willie Wise, Snow Hill, Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Cerebral Vascular Accident</i>						<i>8 days</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Epilepsy, Idiopathic Bradycardia</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/16/56</i> , 19 <i>56</i> , to <i>11/25/56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/25/56</i> , 19 <i>56</i> , and that death occurred at <i>9:15 P.</i> M., from the causes and on the date stated above.							
SIGNATURE <i>David J. Schure</i>				ADDRESS (Street, city, town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>Nov. 27 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Nov. 27/56</i>		NAME OF CEMETERY OR CREMATORY <i>County Cemetery</i>		LOCATION (City, town, or county) (State) <i>Snow Hill, Md</i>	
24. REC'D BY REGISTRAR <i>9 1956</i>		REGISTRAR'S SIGNATURE <i>Mary K. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Thomas</i>		ADDRESS <i>Snow Hill, Md</i>	

CERTIFICATE OF DEATH

Reg. Off. No.

1. NAME OF DECEASED

2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. COLOR
9. RELIGION
10. EDUCATION
11. PRESENT ADDRESS
12. PLACE OF DEATH
13. DATE OF DEATH
14. CAUSE OF DEATH
15. MANNER OF DEATH
16. SIGNATURE OF PHYSICIAN
17. SIGNATURE OF REGISTRAR
18. SIGNATURE OF WITNESSES
19. SIGNATURE OF DECEASED
20. SIGNATURE OF NEXT OF KIN
21. SIGNATURE OF CLERGYMAN
22. SIGNATURE OF CHURCH OFFICER
23. SIGNATURE OF BURIAL OFFICER
24. SIGNATURE OF FUNERAL HOME
25. SIGNATURE OF CEMETERY
26. SIGNATURE OF INTERMENT

DISPOSITION

THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT AND MUST BE FILED WITH THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DATE OF DEATH. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS COMPLETED AND FILED IN ACCORDANCE WITH THE REQUIREMENTS OF THE MARYLAND DEPARTMENT OF HEALTH. THE REGISTRAR IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED HEREON, BUT IS RESPONSIBLE FOR THE COMPLETION AND FILING OF THIS CERTIFICATE. THE REGISTRAR IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED HEREON, BUT IS RESPONSIBLE FOR THE COMPLETION AND FILING OF THIS CERTIFICATE.

BUREAU V. S.

NOV 29 1956

RECEIVED

11858

11879

CERTIFICATE OF DEATH

Reg. Dist. No. 332

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>SALISBURY</u>	<u>9 Days</u>	TOWN <u>BISHOPVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>PENINSULA GENERAL HOSPITAL</u>			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
(First) (Middle) (Last)			
<u>MICHAEL Dundon AMES</u>		<u>NOVEMBER 3 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>MALE</u>	<u>WHITE</u>		<u>April 6/1893</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>63/6/29</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Rail Mail Carrier</u>		<u>US Government</u>	<u>Baltimore Md</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Charles H. Ames</u>		<u>Estelle Dundon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<u>yes</u>		<u>None</u>	<u>Mr. August J. Ames, Bishopville Md</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A)		INTERVAL BETWEEN ONSET AND DEATH	
<u>Coronary Artery Thrombosis</u>		<u>Minutes</u>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO			
(B) <u>Coronary Artery Atherosclerosis</u>			
(C) <u>Myocardial Insufficiency</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>2 month</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-27</u> , 19 <u>56</u> , to <u>11-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-3</u> , 19 <u>56</u> , and that death occurred at <u>5:10</u> P.M., from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>David Selman</u>		<u>Nov. 3, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
<u>Removal</u>		<u>Nov. 6/56</u>	
DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Nov. 6/56</u>		<u>Odd Fellows Cemetery</u>	
REGISTRAR'S SIGNATURE		LOCATION (City, town, or county)	
<u>Mary H. Selman</u>		<u>Bishopville, Md</u>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Walter E. Amis</u>		<u>Snow Hill, Md</u>	

VS A156-1-55 10M

CERTIFICATE OF DEATH

File No.

1. DEATH RECORD - FORM OF DEATH

2. PLACE OF DEATH

HANNAH

HANNAH

DATE OF DEATH

BUREAU V. 31

1956

10/7

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11880 CERTIFICATE OF DEATH

11859

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>108 First St.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Beaty</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 1 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u>	8. DATE OF BIRTH <u>October 31-1956</u>	9. AGE last birthday yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Eugene Beaty</u>				14. MOTHER'S MAIDEN NAME <u>Tuanita Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Father + mother</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A) <u>Premature (1 lb 9 oz - approx 24 hrs gestation)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/31/56</u> , 19 <u>56</u> , to <u>1 Nov 56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/31/56</u> , 19 <u>56</u> , and that death occurred at <u>9:53</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. W. Anderson</u>		M.D. <u>926 Madison St. Salisbury</u>		DATE SIGNED <u>11/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		DATE THEREOF <u>11/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital Salisbury Md</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
24. REC'D BY REGISTRAR <u>11-6-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

2082193XVO

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED

William Henry Harrison

2. SEX

Male

3. AGE

65

4. DATE OF BIRTH

1881

5. PLACE OF BIRTH

England

6. OCCUPATION

Teacher

7. CAUSE OF DEATH

Heart Disease

8. PLACE OF DEATH

Home

9. DATE OF DEATH

October 21, 1956

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF CLERK

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CLERK

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CLERK

23. SIGNATURE OF JURY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF CLERK

27. SIGNATURE OF JURY

28. SIGNATURE OF JUDGE

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF CLERK

31. SIGNATURE OF JURY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF SHERIFF

34. SIGNATURE OF CLERK

35. SIGNATURE OF JURY

36. SIGNATURE OF JUDGE

37. SIGNATURE OF SHERIFF

38. SIGNATURE OF CLERK

39. SIGNATURE OF JURY

40. SIGNATURE OF JUDGE

41. SIGNATURE OF SHERIFF

42. SIGNATURE OF CLERK

43. SIGNATURE OF JURY

44. SIGNATURE OF JUDGE

45. SIGNATURE OF SHERIFF

46. SIGNATURE OF CLERK

47. SIGNATURE OF JURY

48. SIGNATURE OF JUDGE

49. SIGNATURE OF SHERIFF

50. SIGNATURE OF CLERK

BUREAU V. 8

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11860

11923 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. LENGTH OF STAY IN 1b <u>13 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main St.</u>				d. STREET ADDRESS <u>Main St.</u>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>JAMES</u> Last <u>Bounds</u>				4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 10, 1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jones Bounds</u>				14. MOTHER'S MAIDEN NAME <u>Anna M. White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Vernon Powell - Salisbury, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized Arterio sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 1</u>, 19<u>56</u>, to <u>11/27</u>, 19<u>56</u>, that I last saw the deceased alive on <u>11/27</u>, 19<u>56</u>, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>W. B. Smith</u> M.D. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>11/27/56</u> PHYSICIAN'S NAME (Type) <u>DR. WILLIAM B. SMITH</u> <u>THE MEDICAL CENTER</u> <u>RT. 2, SALISBURY, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Allen MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co.</u> ADDRESS <u>Salisbury</u>				24a. REC'D BY REGISTRAR <u>DATE 11-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. H. H. H. H.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		MD		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAN 10 1956		BALTIMORE		MD		U.S.A.		JAN 10 1956		BALTIMORE		MD		U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE	
JAN 10 1956		BALTIMORE		MD		U.S.A.		JAN 10 1956		BALTIMORE		MD		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAN 10 1956		BALTIMORE		MD		U.S.A.		JAN 10 1956		BALTIMORE		MD		U.S.A.	

BUREAU V. 5

NOV 30 1956

RECEIVED

11881 CERTIFICATE OF DEATH

11861

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Wiconico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wiconico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 513 Wailes St				d. STREET ADDRESS 513 Wailes St			
3. NAME OF DECEASED (Type or print) First KATHERINE Middle ELIZABETH Last BOUNDS				4. DATE OF DEATH Month November Day 6 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1889	9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wiconico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Hooten Parsons				14. MOTHER'S MAIDEN NAME (book) Mary Ann Wilkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Luther H. Bounds (Husband) 513 Wailes St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Cerebral Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Debility DUE TO (c) Cerebral Failure of Liver.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-1 , 19 56 , to 11-6 , 19 56 , that I last saw the deceased alive on 11/6 , 19 56 , and that death occurred at 8:15 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. B. Smith M.D.				ADDRESS (Street, city or town, state) Medical Center		DATE SIGNED Nov. 7 1956	
PHYSICIAN'S NAME (Type) Dr. William B. Smith M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1956		22c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery		22d. LOCATION (City, town, or county) (State) Siloam, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				ADDRESS 1018 1956		24a. REC'D BY REGISTRAR Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 8 1956

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11862

Reg. Dist. No. 232

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>1 wk</u>		TOWN <u>Mardella</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>Route #2</u>			
3. NAME OF DECEASED (Type or Print) <u>Flossie E. Brown</u>				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>10</u> (Year) <u>19 56</u>			
5. SEX <u>F. M.</u>	6. COLOR OR RACE <u>AA</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-2-04</u>		9. AGE last birthday <u>52</u> yrs.	10. IF UNDER 1 YEAR (Months) <u>11</u> (Days) <u>10</u> (Hours) <u>56</u> (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Basket factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hovington</u>				14. MOTHER'S MAIDEN NAME <u>Eugenia Quinton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-2857</u>		17. INFORMANT & ADDRESS <u>Mrs. Pauline Hill, Sharptown, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
170X IMMEDIATE CAUSE (A) <u>Generalized carcinoma of the</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>C. A. of Left Breast</u>						<u>8 mo.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-19</u> , 19 <u>52</u> , to <u>11-12</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>10-18</u> , 19 <u>52</u> , and that death occurred at <u>8 A</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE THEREOF <u>11-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Sharptown Cemetery</u>		LOCATION (City, town, or county) <u>Sharptown, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mary Holladay</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u>		ADDRESS <u>Funeral Home, Easton, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

2. MEDICAL HISTORY (Print in Reverse)

3. PLACE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Date of death

6. Time of death

7. Place of death

8. Cause of death

9. Immediate cause of death

10. Underlying cause of death

11. Contributing cause of death

12. Date of death

13. Signature of physician

14. Signature of registrar

15. Date of death

16. Place of death

17. Cause of death

18. Immediate cause of death

19. Underlying cause of death

20. Contributing cause of death

BUREAU V. 31

NOV 23 1956

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ENCLOSURE

11883 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield, Maryland			
c. LENGTH OF STAY IN 1b 1 yr. 25 days				d. STREET ADDRESS RFD #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Manie Byrd				4. DATE OF DEATH Month Nov. Day 4 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 20, 1878	
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel J. Somers				14. MOTHER'S MAIDEN NAME Annie Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unk		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism (recurrent) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD DUE TO (c) Arteriosclerosis generalized				INTERVAL BETWEEN ONSET AND DEATH 3 hrs. ? ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca of rt. breast (amputated)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 9. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crisfield				20g. (County) Trid.		20h. (State) Trid.	
21. I certify that I attended the deceased from Oct. 10, 19 55 , to Nov. 4, 19 56 , that I last saw the deceased alive on Nov. 4, 19 56 , and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Nov. 4, 1956 DATE SIGNED							
ACTUAL SIGNATURE L. V. Maldve				M.D. Nov. 4, 1956			
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		11/7/56		Asbury		Crisfield Trid.	
23. FUNERAL DIRECTOR'S SIGNATURE L. V. Maldve				ADDRESS Crisfield Trid.		24a. REC'D BY REGISTRAR DATE 11-8-56	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloway		per J.P.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		1910		BALTIMORE		MD		MD		USA	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		DISEASE	
White		White		Roman Catholic		High School		Laborer		Natural		Heart Disease		Coronary Artery Disease	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
1955		BALTIMORE		MD		MD		USA		1955		BALTIMORE		MD	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF MINISTER		NAME OF CHURCH		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF BURIAL	
J. H. Harris		St. Mary's Hospital		J. H. Harris		St. Mary's Church		St. Mary's Church		St. Mary's Funeral Home		St. Mary's Cemetery		St. Mary's Burial	
NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
NAME OF SIGNATURE		NAME OF SIGNATURE		NAME OF SIGNATURE		NAME OF SIGNATURE		NAME OF SIGNATURE		NAME OF SIGNATURE		NAME OF SIGNATURE		NAME OF SIGNATURE	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

RECEIVED

BUREAU V. 2

NOV 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11924 CERTIFICATE OF DEATH

11864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Delmar				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3				d. STREET ADDRESS R.D.# 3			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MILLARD Middle JAMES Last CAMPBELL				4. DATE OF DEATH Month November Day 9th Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 22, 1873	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 17 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Lambert Campbell				14. MOTHER'S MAIDEN NAME Charlotte Ann Parsons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Harold J. Campbell (Son) 822 E. Church St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Grove St. DATE SIGNED Nov. 10 1956							
ACTUAL SIGNATURE Ernest M. Larmore M.D.				PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore M.D. Delmar, Delaware			
22a. BURIAL, CREMATION, REMOVAL Burial		22b. DATE THEREOF Nov. 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR Nov 14 1956		24b. REGISTRAR'S SIGNATURE H. H. Hedrick	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
John Doe		Male		45		White		Teacher		Baltimore, Md		Jan 1, 1950		Jan 10, 1950		Baltimore, Md		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]	
16. PLACE OF INTERMENT		17. NAME OF CEMETERY		18. DATE OF INTERMENT		19. NAME OF MINISTER		20. NAME OF CHURCH		21. NAME OF FUNERAL HOME		22. NAME OF UNDERTAKER		23. NAME OF CARRIER		24. NAME OF DRIVER		25. NAME OF ASSISTANT		26. NAME OF ATTENDANT		27. NAME OF BURIAL		28. NAME OF CREMATION		29. NAME OF URN		30. NAME OF CASK	
St. Mary's Church		St. Mary's Cemetery		Jan 10, 1950		Rev. John Smith		St. Mary's Church		John Doe & Son		John Doe & Son		John Doe & Son		John Doe & Son		John Doe & Son		John Doe & Son		John Doe & Son		John Doe & Son		John Doe & Son		John Doe & Son	

BUREAU V. S.

NOV 14 1956

RECEIVED

11884 CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 4 weeks				d. STREET ADDRESS R.D. # 1 (St. Luke Rd)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Causey				4. DATE OF DEATH Month Nov. Day 18 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/1888		9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fruitland, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Thomas Brumbley			
14. MOTHER'S MAIDEN NAME Ellen Marie Jones				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Ethel Jones (Daughter) R.D. # 2 Eden, Md. Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis gen. (c) ?							INTERVAL BETWEEN ONSET AND DEATH 5 d
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralytic ideas - hemiplegia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 19 p. m. Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 10-22, 19 56 to 11-18, 19 56 , that I last saw the deceased alive on 11/18 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. V. Maldve				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				DATE SIGNED 11/18/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Persons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR Nov 20 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1905		BALTIMORE		BALTIMORE		BALTIMORE		1950		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
LABORER		1950		BALTIMORE		BALTIMORE		BALTIMORE		1950		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1950		BALTIMORE		BALTIMORE		BALTIMORE		1950		BALTIMORE		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		1950		BALTIMORE		BALTIMORE		BALTIMORE		1950		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1950		BALTIMORE		BALTIMORE		BALTIMORE		1950		BALTIMORE		BALTIMORE	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1950		BALTIMORE		BALTIMORE		BALTIMORE		1950		BALTIMORE		BALTIMORE	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11866

11885 CERTIFICATE OF DEATH

Reg. Dist. No.

241332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 20x-2	
3. NAME OF DECEASED (Type or print) Walter Chaplain		4. DATE OF DEATH Month Nov. Day 16 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James F. Chaplain		14. MOTHER'S MAIDEN NAME Daisy Rolle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterioscl. cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 0 hrs ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Syndrome		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6 , 19 55 , to Nov. 16 , 19 56 , that I last saw the deceased alive on Nov. 16 , 19 56 , and that death occurred at 7:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) L. V. Maldve		DATE SIGNED 11/17/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-56	
22c. NAME OF CEMETERY OR CREMATORY Christ Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels, Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Harrison		24a. REC'D BY REGISTRAR Nov 19, 56	
ADDRESS St. Michaels, Md		24b. REGISTRAR'S SIGNATURE Mary Hollaway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11867

11925 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
c. LENGTH OF STAY IN 1b 9 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hayword Ave.		d. STREET ADDRESS Hayword Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SALLIE Middle LENORA Last CHATHAM		4. DATE OF DEATH Month 11 Day 11 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Goslee		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Wm. K. Adkins		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Degenerative Heart Disease 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Continued	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-10 , 19 53 , to 11-11 , 19 56 that I last saw the deceased alive on 11-11 , 19 56 , and that death occurred at 1 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilber R. Ellis M.D.		ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 11-12-56	
PHYSICIAN'S NAME (Type) Wilber R. Ellis		Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/14/1956	22c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery	22d. LOCATION (City, town, or county) (State) Siloam, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE George C. Thier ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE 11-13-56	24b. REGISTRAR'S SIGNATURE Mary W. Holloway <i>Open J. L. P.</i>

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11868

11886 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>VIRGINIA</u>		COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place) <u>4 Hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CHINCOTEAGUE 83x-3</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS <u>S. MAIN STREET</u>			
3. NAME OF DECEASED (Type or Print) <u>GRACE T CONANT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 2 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Feb. 5, 1880</u>		9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chincoteague, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>SARAH DAISEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Wm J. Conant</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Artery Thrombosis</u>						<u>8 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Acute pulmonary edema</u>						<u>8 hours</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Heart Disease</u>						<u>one year</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>ggs</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>11-2</u> , 19 <u>56</u> , to <u>11-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-3</u> , 19 <u>56</u> , and that death occurred at <u>11:10</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>David Gilmore</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md.</u>		DATE SIGNED <u>Nov. 3, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>NOV. 4, 1956</u>		NAME OF CEMETERY, OR CREMATORY <u>Downings</u>		LOCATION (City, town, or county) (State) <u>OAK HALL, Va</u>	
24. REC'D BY REGISTRAR DATE <u>11-12-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Lalyer</u>		ADDRESS	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11887 CERTIFICATE OF DEATH

11869

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>		TOWN <u>White Haven</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>6 days</u>		STREET ADDRESS <u>Tyaskin, Md.</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED (Type or Print) <u>Phineas Edwin Conway</u>				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>A.A.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>7-14-1893</u>	
9. AGE last birthday <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>White Haven, Wicomico Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Conway</u>				14. MOTHER'S MAIDEN NAME <u>Arwilla Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>167-20-9645</u>		17. INFORMANT & ADDRESS <u>325 Poplar Hill Ave. Mrs. G. D. White, Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
ANTECEDENT CAUSE(S) (B) <u>Coronary Artery Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u></u>							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>five</u> 19<u>56</u>, to <u>Nov. 17, 1956</u>, that I last saw the deceased alive on <u>Nov. 17, 1956</u>, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David J. Schuore</u> M.D. <u>Salisbury, Md.</u>				DATE SIGNED <u>Nov. 17, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11-20-56</u>		NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>White Haven, Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR <u>11-23-56</u>		REGISTRAR'S SIGNATURE <u>Mary Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>			

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11888 CERTIFICATE OF DEATH

13045

Reg. Dist. No. 332

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Wicomico</i>	STATE <i>md</i> COUNTY <i>Wicomico</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	LENGTH OF STAY (In this place) <i>Life</i>
CITY OR TOWN <i>Salisbury</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury md</i>	STREET ADDRESS <i>806 Lake St</i>	(If rural, give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <i>Warren</i> (First) <i>Dashill</i> (Middle) <i>Dashill</i> (Last)		4. DATE OF DEATH <i>11</i> (Month) <i>27</i> (Day) <i>19</i> (Year) <i>56</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify) <i>married</i>	8. DATE OF BIRTH <i>12-25-85</i>
9. AGE last birthday <i>71</i> yrs.	IF UNDER 1 YEAR Months <i>11</i> Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Geo. Dashill</i>		14. MOTHER'S MAIDEN NAME <i>Berriett Coulbourne</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>✓</i> <i>WMI</i> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <i>P</i>	
17. INFORMANT & ADDRESS <i>Ballie Dashill</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>420.0 Arteriosclerotic Heart Disease</i>			<i>10 months</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>			<i>Indefinite</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>20 Feb</i> , 19 <i>56</i> , to <i>27 Nov</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>27 Feb</i> , 19 <i>56</i> , and that death occurred at <i>10:30</i> , from the causes and on the date stated above.			
SIGNATURE <i>E. Russell</i>		DATE SIGNED <i>1 Dec 56</i>	
ADDRESS (Street, city, town, state) <i>652 W Main Salisbury md</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>mt Vernon Cem</i>	
DATE THEREOF <i>12-2-56</i>		LOCATION (City, town, or county) <i>mt Vernon md</i>	
24. REC'D BY REGISTRAR <i>Maryell Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Boone Booker West</i>	
DATE <i>12-7-56</i>		ADDRESS	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF MINISTER

18. SIGNATURE OF CLERGYMAN

19. SIGNATURE OF RABBI

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

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58. SIGNATURE OF OTHER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11889 CERTIFICATE OF DEATH

11870
237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS In Village	
3. NAME OF DECEASED (Type or print) First FULTON Middle EMORY Last DENNIS		4. DATE OF DEATH Month NOV. Day 28th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1904
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 8 Days 25	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Willards Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ray A. Dennis		14. MOTHER'S MAIDEN NAME Hester Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Mr. Ray A. Dennis (Father)	
17. INFORMANT Mr. Ray A. Dennis (Father)		Address Willards, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 440 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) thrombemia 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Vascular disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH contamin "
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-25 , 19 56 , to 11-28 , 19 56 , that I last saw the deceased alive on 11-28 , 19 56 , and that death occurred at 6:53P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard R. Ellis Jr.		ADDRESS (Street, city or town, state) Medical Center DATE SIGNED Nov. 30 1956	
PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr. MD.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 1st, 1956	22c. NAME OF CEMETERY OR CREMATORY Willards Cemetery	22d. LOCATION (City, town, or county) (State) Willards, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. REC'D BY REGISTRAR DEC 3 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11926 CERTIFICATE OF DEATH

11871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomicoe MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown R. P. D.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First William Middle Lafayette Last Donoho		4. DATE OF DEATH Month Nov. (13) Day 13 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1872
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 11 Days 10 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Packer		10b. KIND OF BUSINESS OR INDUSTRY Retired Oyster	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William F. Donoho		14. MOTHER'S MAIDEN NAME Emily Austin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 218-30-1841	
17. INFORMANT Mrs. Bernice Davis		Address Oxford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 153X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration & Hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 13, 1955 , to Nov 13, 1956 , that I last saw the deceased alive on Nov 13, 1956 , and that death occurred at 8:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. S. Kuhlman		ADDRESS (Street, city or town, state) Sharptown - Md	
PHYSICIAN'S NAME (Type) H. S. Kuhlman		DATE SIGNED 11/13/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-56	
22c. NAME OF CEMETERY OR CREMATORY Oxford Demetery		22d. LOCATION (City, town, or county) (State) Oxford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Williams		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE 11/17/56		24b. REGISTRAR'S SIGNATURE Mary C. Owens	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. EDUCATION</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. TIME OF DEATH</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF REGISTRAR</p>		<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. DATE OF DEATH</p>		<p>18. TIME OF DEATH</p>		<p>19. PLACE OF DEATH</p>		<p>20. TIME OF DEATH</p>	
<p>21. DATE OF DEATH</p>		<p>22. TIME OF DEATH</p>		<p>23. PLACE OF DEATH</p>		<p>24. TIME OF DEATH</p>	
<p>25. DATE OF DEATH</p>		<p>26. TIME OF DEATH</p>		<p>27. PLACE OF DEATH</p>		<p>28. TIME OF DEATH</p>	
<p>29. DATE OF DEATH</p>		<p>30. TIME OF DEATH</p>		<p>31. PLACE OF DEATH</p>		<p>32. TIME OF DEATH</p>	
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<p>37. DATE OF DEATH</p>		<p>38. TIME OF DEATH</p>		<p>39. PLACE OF DEATH</p>		<p>40. TIME OF DEATH</p>	
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<p>57. DATE OF DEATH</p>		<p>58. TIME OF DEATH</p>		<p>59. PLACE OF DEATH</p>		<p>60. TIME OF DEATH</p>	
<p>61. DATE OF DEATH</p>		<p>62. TIME OF DEATH</p>		<p>63. PLACE OF DEATH</p>		<p>64. TIME OF DEATH</p>	
<p>65. DATE OF DEATH</p>		<p>66. TIME OF DEATH</p>		<p>67. PLACE OF DEATH</p>		<p>68. TIME OF DEATH</p>	
<p>69. DATE OF DEATH</p>		<p>70. TIME OF DEATH</p>		<p>71. PLACE OF DEATH</p>		<p>72. TIME OF DEATH</p>	
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<p>81. DATE OF DEATH</p>		<p>82. TIME OF DEATH</p>		<p>83. PLACE OF DEATH</p>		<p>84. TIME OF DEATH</p>	
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<p>89. DATE OF DEATH</p>		<p>90. TIME OF DEATH</p>		<p>91. PLACE OF DEATH</p>		<p>92. TIME OF DEATH</p>	
<p>93. DATE OF DEATH</p>		<p>94. TIME OF DEATH</p>		<p>95. PLACE OF DEATH</p>		<p>96. TIME OF DEATH</p>	
<p>97. DATE OF DEATH</p>		<p>98. TIME OF DEATH</p>		<p>99. PLACE OF DEATH</p>		<p>100. TIME OF DEATH</p>	

RECEIVED
 NOV 19 1956
 BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11890 CERTIFICATE OF DEATH

11872 332

Reg. Dist. No. 184

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6-1/2 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ETHEL Smith * * Dunn				4. DATE OF DEATH Month November Day 6th Year 19 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1896	
9. AGE (In years last birthday) yrs. 60		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William Smith			
14. MOTHER'S MAIDEN NAME Cecilia Maynard				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) --			
16. SOCIAL SECURITY NO. 145-14-9906				17. INFORMANT Address Deer's Head Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cerebral arteriosclerosis DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from April 19, 19 56 , to Nov. 6, 19 56 , that I last saw the deceased alive on Nov. 6, 19 56 , and that death occurred at 10:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andres Grisolia M.D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 11/6/56			
PHYSICIAN'S NAME (Type) Andres Grisolia, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9 1956		22c. NAME OF CEMETERY OR CREMATORY Wt Polvary		22d. LOCATION (City, town, or county) (State) Aberdeen Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Carving Aberdeen Maryland				24a. REC'D BY REGISTRAR DATE Nov 7-56		24b. REGISTRAR'S SIGNATURE Della R Perry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. DATE OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>		<p>9. CAUSE OF DEATH [REDACTED]</p>	
<p>10. MEDICAL HISTORY [REDACTED]</p>		<p>11. HISTORY OF PRESENT ILLNESS [REDACTED]</p>		<p>12. POST-MORTEM EXAMINATION [REDACTED]</p>	
<p>13. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>14. SIGNATURE OF CORONER [REDACTED]</p>		<p>15. SIGNATURE OF WITNESSES [REDACTED]</p>	

BUREAU V. S.

NOV 9 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11891 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11873

Reg. Dist. No. 337

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>Most of life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>224 Lake St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel James Elzey</u>				4. DATE OF DEATH Month Day Year <u>11-29-56</u> <u>19</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Arcade Shoe Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Princess Anne, Md. R.F.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Elzey</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Maddox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-5271</u>		17. INFORMANT Address <u>Salisbury, Md.</u> <u>Mrs. Novella Whittington, 805 East Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive cardio-vascular disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u> <u>Years</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found unconscious in yard of home by taxi driver at 5:30 A.M.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Salisbury, Wicomico Co. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DATE SIGNED <u>12-3-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 5 1956
BUREAU V. A.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11892
CERTIFICATE OF DEATH11874
337
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Salisbury</u>		Since <u>11/8/56</u>		TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u> <u>Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>Pemberton Drive</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Kate</u> <u>-</u> <u>Fooks</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov.</u> <u>17</u> <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 8, 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Jones</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Bloodsworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Pemberton Drive</u> <u>Carl Jones (Bro) Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
002X IMMEDIATE CAUSE (A) <u>Cardio-Vascular Disease</u>						<u>20 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis</u>						<u>20 years?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cystic Goitre</u>						<u>20 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> <u>8</u> , 19 <u>56</u> , to <u>Nov.</u> <u>17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov.</u> <u>17</u> , 19 <u>56</u> , and that death occurred at <u>12:30AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				DATE SIGNED <u>Salisbury</u> <u>Nov. 17, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>NOV 19 1956</u> DATE		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY - SALISBURY, MARYLAND</u> ADDRESS			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11875

11893 CERTIFICATE OF DEATH

Reg. Dist. No. 932

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 Yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Pr. Sanl.				d. STREET ADDRESS 124 N. Division			
3. NAME OF DECEASED (Type or print) First William Middle Fooks Last Fooks				4. DATE OF DEATH Month 11 Day 27 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1885	9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months 11 Days 27 Hours 156	IF UNDER 24 HRS. Hours 156 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce		10b. KIND OF BUSINESS OR INDUSTRY Grocer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Merrill H. Fooks				14. MOTHER'S MAIDEN NAME Emma Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-1032 A		17. INFORMANT Address Mrs. Leroy Wingate, 901 E. Main St. Salisbury			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 26 , 19 54 , to Nov. 26 , 19 56 , that I last saw the deceased alive on Nov. 26 , 19 56 , and that death occurred at 5 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley M.D.				ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley, 116 East Main St, Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/56		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Norman T. Baker				24a. REC'D BY REGISTRAR DATE 11-27-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

STATE OF MARYLAND DEPARTMENT OF HEALTH - BATHING

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES H. HARRIS</p>		<p>AGE 65</p>		<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH October 23, 1956</p>		<p>TIME OF DEATH 10:30 AM</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Baltimore</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>MANNER OF DEATH Natural</p>		<p>EDUCATION High School</p>		<p>OCCUPATION Retired</p>	
<p>DATE OF BIRTH November 10, 1891</p>		<p>PLACE OF BIRTH Maryland</p>		<p>EDUCATION High School</p>		<p>OCCUPATION Retired</p>	
<p>DATE OF DEATH October 23, 1956</p>		<p>TIME OF DEATH 10:30 AM</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Baltimore</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>MANNER OF DEATH Natural</p>		<p>EDUCATION High School</p>		<p>OCCUPATION Retired</p>	
<p>DATE OF BIRTH November 10, 1891</p>		<p>PLACE OF BIRTH Maryland</p>		<p>EDUCATION High School</p>		<p>OCCUPATION Retired</p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11927 CERTIFICATE OF DEATH

11876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico		c. LENGTH OF STAY IN 1b 46 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle Ada Last French		4. DATE OF DEATH Month Nov. Day 18 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY sewing	
11. BIRTHPLACE (State or foreign country) Harrold, South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. French		14. MOTHER'S MAIDEN NAME Ada Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-01-7787	
17. INFORMANT Mr. Jay French		Address Quantico, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH instantaneous 1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-23 , 19 56 , to 10-18 , 19 56 , that I last saw the deceased alive on 11-15 , 19 56 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11/18/56 ACTUAL SIGNATURE H. A. Briele M.D. Salisbury, Md. PHYSICIAN'S NAME (Type) Henry A. Briele, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-20-1956	
22c. NAME OF CEMETERY OR CREMATORY Mardels cemetery		22d. LOCATION (City, town, or county) (State) Mardels, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Levin Wilson		24a. REC'D BY REGISTRAR Nov 29 1956	
ADDRESS Princess Anne, Md.		24b. REGISTRAR'S SIGNATURE Mary T. Holloway	

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NOV 29 1956

RECEIVED

11894 CERTIFICATE OF DEATH

11877
322

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place) <u>26 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DELMAR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>103 CHESTNUT ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE WILLIAM GORDY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 18 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3-3-1895</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Delmar Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Virgil Gordy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane LeCates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>716-03-1576</u>		17. INFORMANT & ADDRESS <u>Delmar Gordy - Delmar Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Sclerotic Disease</u>				"			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma of Prostate</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 19 56</u> to <u>Nov 18 56</u> that I last saw the deceased alive on <u>Nov 16 56</u> and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>David G. Gilman</u> M.D. <u>Salisbury Md.</u> DATE SIGNED <u>Nov. 18, 1956</u> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>11-21-56</u> NAME OF CEMETERY OR CREMATORY <u>Mt Olive</u> LOCATION (City, town, or county) <u>Delmar Del</u> (State)							
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Holloways</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Gamm Co - Delmar Del</u>		ADDRESS	
DATE <u>NOV 20 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

REG. NO. 100-100

1. USUAL RESIDENCE (HOUSE OR BUSINESS)

2. PLACE OF DEATH

3. PLACE OF BIRTH

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SEX

9. AGE

10. OCCUPATION

11. MARITAL STATUS

12. RACE

13. COLOR

14. HEIGHT

15. WEIGHT

16. BLOOD TYPE

17. EDUCATION

18. RELIGION

19. SOCIAL SECURITY NUMBER

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF REGISTRAR

23. DATE OF REGISTRATION

24. PLACE OF REGISTRATION

25. COUNTY

26. CITY

27. STATE

28. ZIP CODE

29. TELEPHONE NUMBER

30. FAX NUMBER

31. E-MAIL ADDRESS

32. HOME ADDRESS

33. BUSINESS ADDRESS

34. MAILING ADDRESS

35. SIGNATURE OF NEXT OF KIN

36. DATE OF SIGNATURE

37. PLACE OF SIGNATURE

38. SIGNATURE OF PHYSICIAN

39. DATE OF SIGNATURE

40. PLACE OF SIGNATURE

41. SIGNATURE OF MORTUARY

42. DATE OF SIGNATURE

43. PLACE OF SIGNATURE

44. SIGNATURE OF BURIAL SOCIETY

45. DATE OF SIGNATURE

46. PLACE OF SIGNATURE

47. SIGNATURE OF CEMETERY

48. DATE OF SIGNATURE

49. PLACE OF SIGNATURE

50. SIGNATURE OF FUNERAL HOME

51. DATE OF SIGNATURE

52. PLACE OF SIGNATURE

53. SIGNATURE OF BURIAL SOCIETY

54. DATE OF SIGNATURE

55. PLACE OF SIGNATURE

56. SIGNATURE OF CEMETERY

57. DATE OF SIGNATURE

58. PLACE OF SIGNATURE

59. SIGNATURE OF FUNERAL HOME

60. DATE OF SIGNATURE

61. PLACE OF SIGNATURE

62. SIGNATURE OF BURIAL SOCIETY

63. DATE OF SIGNATURE

64. PLACE OF SIGNATURE

65. SIGNATURE OF CEMETERY

66. DATE OF SIGNATURE

67. PLACE OF SIGNATURE

68. SIGNATURE OF FUNERAL HOME

69. DATE OF SIGNATURE

70. PLACE OF SIGNATURE

71. SIGNATURE OF BURIAL SOCIETY

72. DATE OF SIGNATURE

73. PLACE OF SIGNATURE

74. SIGNATURE OF CEMETERY

75. DATE OF SIGNATURE

76. PLACE OF SIGNATURE

77. SIGNATURE OF FUNERAL HOME

78. DATE OF SIGNATURE

79. PLACE OF SIGNATURE

80. SIGNATURE OF BURIAL SOCIETY

81. DATE OF SIGNATURE

82. PLACE OF SIGNATURE

83. SIGNATURE OF CEMETERY

84. DATE OF SIGNATURE

85. PLACE OF SIGNATURE

86. SIGNATURE OF FUNERAL HOME

87. DATE OF SIGNATURE

88. PLACE OF SIGNATURE

89. SIGNATURE OF BURIAL SOCIETY

90. DATE OF SIGNATURE

91. PLACE OF SIGNATURE

92. SIGNATURE OF CEMETERY

93. DATE OF SIGNATURE

94. PLACE OF SIGNATURE

95. SIGNATURE OF FUNERAL HOME

96. DATE OF SIGNATURE

97. PLACE OF SIGNATURE

98. SIGNATURE OF BURIAL SOCIETY

99. DATE OF SIGNATURE

100. PLACE OF SIGNATURE

101. SIGNATURE OF CEMETERY

102. DATE OF SIGNATURE

103. PLACE OF SIGNATURE

104. SIGNATURE OF FUNERAL HOME

105. DATE OF SIGNATURE

106. PLACE OF SIGNATURE

107. SIGNATURE OF BURIAL SOCIETY

108. DATE OF SIGNATURE

109. PLACE OF SIGNATURE

110. SIGNATURE OF CEMETERY

111. DATE OF SIGNATURE

112. PLACE OF SIGNATURE

113. SIGNATURE OF FUNERAL HOME

114. DATE OF SIGNATURE

115. PLACE OF SIGNATURE

116. SIGNATURE OF BURIAL SOCIETY

117. DATE OF SIGNATURE

118. PLACE OF SIGNATURE

119. SIGNATURE OF CEMETERY

120. DATE OF SIGNATURE

121. PLACE OF SIGNATURE

122. SIGNATURE OF FUNERAL HOME

123. DATE OF SIGNATURE

124. PLACE OF SIGNATURE

125. SIGNATURE OF BURIAL SOCIETY

126. DATE OF SIGNATURE

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NOV 20 1956

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PHOTOGRAPH

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11895 CERTIFICATE OF DEATH

11878

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place) 10 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital				STREET ADDRESS (If rural give location) Pemberton Drive Route # 5			
3. NAME OF DECEASED (Type or Print) (First) Susie (Middle) Anna (Last) Goslee				4. DATE OF DEATH (Month) (Day) (Year) 11 - 22 - 1956			
5. SEX Female	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 3-21-56	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months 8 Days 1		IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY At home - Farm		11. BIRTHPLACE (State or foreign country) Rock-a-walkin, Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Elzey				14. MOTHER'S MAIDEN NAME Harriett Dashiell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Pemberton Drive Thos. Goslee, Salisbury, Md. Rt. # 5			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
416X IMMEDIATE CAUSE (A)				Hypertensive Cardiovascular Disease		unk.	
ANTECEDENT CAUSE(S) DUE TO				probably Rheumatic Heart Disease		unk.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Renal Failure		2 weeks	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 12, 1956 to Nov 22, 1956 , that I last saw the deceased alive on Nov 22, 1956 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE D. Herbert Lembley		M.D.		ADDRESS (Street, city, town, state) Salisbury Md		DATE SIGNED Nov 23 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-25-56		NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR NOV 27 1956		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF COURT

22. SIGNATURE OF STATE

23. SIGNATURE OF UNION

24. SIGNATURE OF COUNTRY

25. SIGNATURE OF WORLD

26. SIGNATURE OF UNIVERSE

27. SIGNATURE OF GOD

28. SIGNATURE OF HEAVEN

29. SIGNATURE OF EARTH

30. SIGNATURE OF WATER

31. SIGNATURE OF FIRE

32. SIGNATURE OF AIR

33. SIGNATURE OF LIGHT

34. SIGNATURE OF DARKNESS

35. SIGNATURE OF LIFE

36. SIGNATURE OF DEATH

37. SIGNATURE OF REBIRTH

38. SIGNATURE OF RESURRECTION

39. SIGNATURE OF JUDGMENT

40. SIGNATURE OF GLORY

41. SIGNATURE OF HONOR

42. SIGNATURE OF WEALTH

43. SIGNATURE OF POWER

44. SIGNATURE OF KNOWLEDGE

45. SIGNATURE OF WISDOM

46. SIGNATURE OF FAITH

47. SIGNATURE OF HOPE

48. SIGNATURE OF CHARITY

49. SIGNATURE OF LOVE

50. SIGNATURE OF PEACE

51. SIGNATURE OF JOY

52. SIGNATURE OF BLISS

53. SIGNATURE OF HAPPINESS

54. SIGNATURE OF SALVATION

55. SIGNATURE OF LIFE EVERLASTING

56. SIGNATURE OF KINGDOM OF GOD

57. SIGNATURE OF HEAVENLY CITY

58. SIGNATURE OF NEW JERUSALEM

59. SIGNATURE OF GATE OF GOD

60. SIGNATURE OF BRIDGE OF GOD

61. SIGNATURE OF PATH OF GOD

62. SIGNATURE OF DOOR OF GOD

63. SIGNATURE OF WINDOW OF GOD

64. SIGNATURE OF ROOF OF GOD

65. SIGNATURE OF FLOOR OF GOD

66. SIGNATURE OF WALL OF GOD

67. SIGNATURE OF CEILING OF GOD

68. SIGNATURE OF STAIRS OF GOD

69. SIGNATURE OF PORCH OF GOD

70. SIGNATURE OF GARDEN OF GOD

71. SIGNATURE OF PALACE OF GOD

72. SIGNATURE OF TEMPLE OF GOD

73. SIGNATURE OF CHURCH OF GOD

74. SIGNATURE OF SYNAGOGUE OF GOD

75. SIGNATURE OF MOSQUE OF GOD

76. SIGNATURE OF TEMPLE OF GOD

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78. SIGNATURE OF SYNAGOGUE OF GOD

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97. SIGNATURE OF CHURCH OF GOD

98. SIGNATURE OF SYNAGOGUE OF GOD

99. SIGNATURE OF MOSQUE OF GOD

100. SIGNATURE OF TEMPLE OF GOD

RECEIVED

BUREAU V. 1

1956

RECEIVED

11896 CERTIFICATE OF DEATH

11879

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 198-2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne Rural I		d. STREET ADDRESS 198-2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Alonga Middle W. Last Green		4. DATE OF DEATH Month Nov. Day II Year 1956		5. SEX male		6. COLOR OR RACE clored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 3, 1890		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Phillips Green		14. MOTHER'S MAIDEN NAME Margaret Collins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes <input checked="" type="checkbox"/> war I		16. SOCIAL SECURITY NO. 2I9-07-5III		17. INFORMANT Mrs Sadie Green Princess Anne, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 5, 1955 to Nov 11, 1955 that I last saw the deceased alive on Nov 10, 1955 , and that death occurred at 2:30 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Princess Anne, Md.		DATE SIGNED Nov 10, 1955		ACTUAL SIGNATURE Eldon G. Markson		PHYSICIAN'S NAME (Type) Eldon G. Markson		22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF II-18-1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) near Princess Anne, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Levin B. Wilson		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE 11-21-56		24b. REGISTRAR'S SIGNATURE Mary Kollanoy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

RECEIVED

NOV 21 1956

BUREAU V. E.

11897 CERTIFICATE OF DEATH

Reg. Dist. No.

118837

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle J. Last Hancock				4. DATE OF DEATH Month November Day 26 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1882	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 23 Days 42 Hours 2					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant				10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Hancock				14. MOTHER'S MAIDEN NAME Mary Brittingham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Wilson Dryden, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Dissecting Aneurysm of Aorta							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dissecting Aneurysm of Aorta							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 10, 1956 to Nov. 26, 1956 , that I last saw the deceased alive on Nov. 26, 1956 , and that death occurred at Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Gilmore				M.D. Medical Center Salisbury 11/29/56			
PHYSICIAN'S NAME (Type) David J. Gilmore				M.D. Jed			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-56		22c. NAME OF CEMETERY OR CREMATORY Whatcoat Cemetery		22d. LOCATION (City, town, or county) (State) Snow Hill, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry D. Watson				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR DEC 4 1956	
						24b. REGISTRAR'S SIGNATURE Mary H. Halloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in no event within 72 hours after death.

BUREAU V. S.

DEC 7 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11928

CERTIFICATE OF DEATH

11881
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 35 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #1				d. STREET ADDRESS Rt. # 1			
3. NAME OF DECEASED (Type or print) WILLIAM Middle HORSEY Last HANDY				4. DATE OF DEATH Month 11 Day 26 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1888	
9. AGE (In years last birthday) 68 6/7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME E. E. Handy		14. MOTHER'S MAIDEN NAME Marian Horsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Vivian T. Handy		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/22 , 19 52 , to 11/26 , 19 56 , that I last saw the deceased alive on 11/26/56 , 19 56 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Fred R. Granse				M.D. Salisbury, Md			
PHYSICIAN'S NAME (Type) Fred R. Granse				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co.				ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE 11-26-56	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway							

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF DECEASED [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
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82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
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88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
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97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

RECEIVED
NOV 28 1956
BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11882 CERTIFICATE OF DEATH

11882

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 124 E. Chestnut St	
3. NAME OF DECEASED (Type or print) First PAUL Middle EDWARD Last HASTINGS		4. DATE OF DEATH Month NOV. Day 3rd Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1887
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter and Painter (Laborer)		10b. KIND OF BUSINESS OR INDUSTRY (Laborer)	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fredrick Hastings		14. MOTHER'S MAIDEN NAME Mary Frances Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Emma A. Hastings (Wife)		Address 124 E. Chestnut St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) you INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Feb, 1955 to 3 Nov, 1956 that I last saw the deceased alive on 3 Nov, 1956 , and that death occurred at 10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 407 Camden Ave. DATE-SIGNED Nov. 5 1956			
ACTUAL SIGNATURE Earl L. Royer		M.D. 407 Camden Ave.	
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 6, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR NOV 7 1956	
		24b. REGISTRAR'S SIGNATURE Mary J. Holloway	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G207, 12/4/56 bh

11883

11899 CERTIFICATE OF DEATH

Reg. Dist. No. 381

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>	LENGTH OF STAY (in this place) <u>3 DAYS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BERLIN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Eleanor KENT Hayward</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>November 23-19 52</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>DEC 26, 1880</u>
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAW</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK CITY N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS DIRICKSON</u>		14. MOTHER'S MAIDEN NAME <u>NORA KENT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT & ADDRESS <u>MRS. HELEN WORRALL MT PAINS</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
561.1 IMMEDIATE CAUSE (A) <u>Mesenteric thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C-V disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Atherosclerotic Stagnated femoral Arterio</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Mesenteric thrombosis, Stagnated femoral Arterio</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-20</u> , <u>19 56</u> , to <u>11-23</u> , <u>19 56</u> , that I last saw the deceased alive on <u>11-23</u> , <u>19 56</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William J. Felt</u>		ADDRESS (Street, city, town, state) <u>MD.</u> DATE SIGNED <u>NOV 28 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/27/56</u>	
NAME OF CEMETERY OR CREMATORY <u>ST PAULS</u>		LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
24. REC'D BY REGISTRAR <u>NOV 28 1956</u>		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna B. Barbaree</u>		ADDRESS <u>Berlin Md.</u>	

12000 CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DEPUTY SHERIFF

20. SIGNATURE OF CONSTABLE

21. SIGNATURE OF ALDERMAN

22. SIGNATURE OF COUNCILMAN

23. SIGNATURE OF SINDIC

24. SIGNATURE OF SENATOR

25. SIGNATURE OF REPRESENTATIVE

26. SIGNATURE OF GOVERNOR

27. SIGNATURE OF COMMISSIONER

28. SIGNATURE OF SECRETARY

29. SIGNATURE OF ASSISTANT SECRETARY

30. SIGNATURE OF CHIEF CLERK

31. SIGNATURE OF DEPUTY CHIEF CLERK

32. SIGNATURE OF CLERK OF THE HOUSE

33. SIGNATURE OF CLERK OF THE SENATE

34. SIGNATURE OF CLERK OF THE JUDICIARY

35. SIGNATURE OF CLERK OF THE COMMISSIONERS

36. SIGNATURE OF CLERK OF THE BOARD OF PUBLIC WORKS

37. SIGNATURE OF CLERK OF THE BOARD OF EDUCATION

38. SIGNATURE OF CLERK OF THE BOARD OF AGRICULTURE

39. SIGNATURE OF CLERK OF THE BOARD OF MINES

40. SIGNATURE OF CLERK OF THE BOARD OF COMMERCE

41. SIGNATURE OF CLERK OF THE BOARD OF LAND AND NATURAL RESOURCES

42. SIGNATURE OF CLERK OF THE BOARD OF PUBLIC UTILITIES

43. SIGNATURE OF CLERK OF THE BOARD OF TRANSPORTATION

44. SIGNATURE OF CLERK OF THE BOARD OF AERONAUTICS

45. SIGNATURE OF CLERK OF THE BOARD OF NAVIGATION

46. SIGNATURE OF CLERK OF THE BOARD OF MARITIME COMMERCE

47. SIGNATURE OF CLERK OF THE BOARD OF FISHERIES

48. SIGNATURE OF CLERK OF THE BOARD OF HUNTING AND FISHING

49. SIGNATURE OF CLERK OF THE BOARD OF GAMES

50. SIGNATURE OF CLERK OF THE BOARD OF AMUSEMENTS

BUREAU V. 3

NOV 28 1956

RECEIVED

11900 CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 511 Poplar Hill Ave				d. STREET ADDRESS 511 Poplar Hill Ave.			
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDWIN Last HOLLOWAY				4. DATE OF DEATH Month NOVEMBER Day 16th Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 4, 1886	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 9 Days 9	IF UNDER 24 HRS. Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Owner of Holloway Tire Co.				10b. KIND OF BUSINESS OR INDUSTRY Wicomico County, Maryland		11. BIRTHPLACE (State or foreign country) U S A	
13. FATHER'S NAME Samuel Joseph Ritchie Holloway				14. MOTHER'S MAIDEN NAME Emma Jane Toadvin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Flora E. Holloway (Wife) Address 511 Poplar Hill Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/6 , 19 54 to 11/16 , 19 56 , that I last saw the deceased alive on 11/13 , 19 56 , and that death occurred at 4 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew C. Mitchell M.D.				ADDRESS (Street, city or town, state) Maryland Ave. (Office)		DATE SIGNED Nov. 17 1956	
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell M.D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR NOV 19 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11885

11901 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 yrs. 9mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardella Springs, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS RFD 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isabelle Middle - Last Hopkins				4. DATE OF DEATH Month Nov. 19, Day 19 , Year 1956			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/1932		9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEONARD HOPKINS Harold Gaines				14. MOTHER'S MAIDEN NAME MARY ANN Sallie Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Deer's Head Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis left upper lobe 962x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Spinal cord severance (c) Fracture dislocation of C-3 - 4						INTERVAL BETWEEN ONSET AND DEATH 3 wks. 3 yrs. 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. s. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 26, 1954 to Nov. 19, 1956 , that I last saw the deceased alive on Nov. 19, 1956 , and that death occurred at 2:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11/19/56 ACTUAL SIGNATURE L. V. Maldve M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24, 1956		22c. NAME OF CEMETERY OR CREMATORY San Domingo Cemetery		22d. LOCATION (City, town, or county) (State) Near Sharptown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE Nov 20, 1956		24b. REGISTRAR'S SIGNATURE Margaret H. Frampton	

DEATH CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
JAMES H. HARRIS		Male		45		1911		Baltimore, Md.		Baltimore, Md.		Heart Disease		1956		10:30 AM		Home		J. H. Harris		J. H. Harris	
Occupation		Marital Status		Education		Religion		Race		Color		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Mental Condition		Other Notes	
None		Married		High School		Catholic		White		White		None		None		None		None		None		None	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist		Signature of Forensic Chemist		Signature of Forensic Anthropologist		Signature of Forensic Entomologist		Signature of Forensic Botanist	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. 3

NOV 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11886

11902

CERTIFICATE OF DEATH

Reg. Dist. No. 328

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA General Hospital</u>		STREET ADDRESS <u>CLARK AVE.</u>	(If rural give location)
3. NAME OF DECEASED (Type or Print) <u>WILLIAM THOMAS HOWARD, IV</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>November 2 19 56</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>new born</u>	8. DATE OF BIRTH <u>11/1/56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. Months Days <u>1 1/2</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Thomas Howard, III</u>		14. MOTHER'S MAIDEN NAME <u>HELEN KATE THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS			
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive Cardiac Decompensation</u>			<u>8 hours</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Hyaline Membrane</u>			<u>36 hrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hemolytic Disease of the Newborn</u>			<u>36 hrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
SIGNATURE <u>MORRIS A. Linselin</u>		ADDRESS (Street, city, town, state) <u>M.D. 117 Camden Ave Salisbury Md 11/2/56</u>	
DATE SIGNED <u>NOV 5 1956</u>		DATE SIGNED <u>11/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/3/56</u>	
24. REC'D BY REGISTRAR <u>NOV 5 1956</u>		NAME OF CEMETERY OR CREMATORY <u>BAPTIST CEMETERY Pocomoke MD</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke Md</u>	

2082252XV5

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Worcester.
MARRIAGE
Pocahontas
CLARK Ave.

Wisconsin
SARISBUR
Peninsular General Hospital

Howard.
November 26
Male. White.

William Thomas Howard
Helen Cole Thomas.

BUREAU V. S.

NOV 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11903 CERTIFICATE OF DEATH

Reg. Dist. No.

11887

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 611 Main St.	
3. NAME OF DECEASED (Type or print) First Govan Middle -- Last Jackson		4. DATE OF DEATH Month Nov. 28, Day 19 Year 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1916
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 1 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheetmetal Worker		10b. KIND OF BUSINESS OR INDUSTRY Factory	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johnny Jackson		14. MOTHER'S MAIDEN NAME Lillian Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 245-07-9424	
17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic congestion of lung 345X DUE TO Multiple sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 day ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 14, 1952 , to Nov. 28, 1956 , that I last saw the deceased alive on Nov. 28, 1956 , and that death occurred at 2:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 11/28/56			
ACTUAL SIGNATURE Andres Grisolia		M.D. Salisbury, Md.	
PHYSICIAN'S NAME (Type) Andres Grisolia, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Avenue	
24a. REC'D BY REGISTRAR C 3		24b. REGISTRAR'S SIGNATURE 1956	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 1921	
5. PLACE OF BIRTH New York, N.Y.		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF DEATH Dec 2, 1956	
9. CAUSE OF DEATH Myocardial Infarction		10. PLACE OF DEATH Home		11. SIGNATURE OF PHYSICIAN J. J. Jones		12. SIGNATURE OF REGISTRAR J. J. Jones	
13. SIGNATURE OF DECEASED J. J. Jones		14. SIGNATURE OF WITNESS J. J. Jones		15. SIGNATURE OF DECEASED J. J. Jones		16. SIGNATURE OF WITNESS J. J. Jones	
17. SIGNATURE OF DECEASED J. J. Jones		18. SIGNATURE OF WITNESS J. J. Jones		19. SIGNATURE OF DECEASED J. J. Jones		20. SIGNATURE OF WITNESS J. J. Jones	
21. SIGNATURE OF DECEASED J. J. Jones		22. SIGNATURE OF WITNESS J. J. Jones		23. SIGNATURE OF DECEASED J. J. Jones		24. SIGNATURE OF WITNESS J. J. Jones	
25. SIGNATURE OF DECEASED J. J. Jones		26. SIGNATURE OF WITNESS J. J. Jones		27. SIGNATURE OF DECEASED J. J. Jones		28. SIGNATURE OF WITNESS J. J. Jones	
29. SIGNATURE OF DECEASED J. J. Jones		30. SIGNATURE OF WITNESS J. J. Jones		31. SIGNATURE OF DECEASED J. J. Jones		32. SIGNATURE OF WITNESS J. J. Jones	
33. SIGNATURE OF DECEASED J. J. Jones		34. SIGNATURE OF WITNESS J. J. Jones		35. SIGNATURE OF DECEASED J. J. Jones		36. SIGNATURE OF WITNESS J. J. Jones	
37. SIGNATURE OF DECEASED J. J. Jones		38. SIGNATURE OF WITNESS J. J. Jones		39. SIGNATURE OF DECEASED J. J. Jones		40. SIGNATURE OF WITNESS J. J. Jones	
41. SIGNATURE OF DECEASED J. J. Jones		42. SIGNATURE OF WITNESS J. J. Jones		43. SIGNATURE OF DECEASED J. J. Jones		44. SIGNATURE OF WITNESS J. J. Jones	
45. SIGNATURE OF DECEASED J. J. Jones		46. SIGNATURE OF WITNESS J. J. Jones		47. SIGNATURE OF DECEASED J. J. Jones		48. SIGNATURE OF WITNESS J. J. Jones	
49. SIGNATURE OF DECEASED J. J. Jones		50. SIGNATURE OF WITNESS J. J. Jones		51. SIGNATURE OF DECEASED J. J. Jones		52. SIGNATURE OF WITNESS J. J. Jones	
53. SIGNATURE OF DECEASED J. J. Jones		54. SIGNATURE OF WITNESS J. J. Jones		55. SIGNATURE OF DECEASED J. J. Jones		56. SIGNATURE OF WITNESS J. J. Jones	
57. SIGNATURE OF DECEASED J. J. Jones		58. SIGNATURE OF WITNESS J. J. Jones		59. SIGNATURE OF DECEASED J. J. Jones		60. SIGNATURE OF WITNESS J. J. Jones	
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65. SIGNATURE OF DECEASED J. J. Jones		66. SIGNATURE OF WITNESS J. J. Jones		67. SIGNATURE OF DECEASED J. J. Jones		68. SIGNATURE OF WITNESS J. J. Jones	
69. SIGNATURE OF DECEASED J. J. Jones		70. SIGNATURE OF WITNESS J. J. Jones		71. SIGNATURE OF DECEASED J. J. Jones		72. SIGNATURE OF WITNESS J. J. Jones	
73. SIGNATURE OF DECEASED J. J. Jones		74. SIGNATURE OF WITNESS J. J. Jones		75. SIGNATURE OF DECEASED J. J. Jones		76. SIGNATURE OF WITNESS J. J. Jones	
77. SIGNATURE OF DECEASED J. J. Jones		78. SIGNATURE OF WITNESS J. J. Jones		79. SIGNATURE OF DECEASED J. J. Jones		80. SIGNATURE OF WITNESS J. J. Jones	
81. SIGNATURE OF DECEASED J. J. Jones		82. SIGNATURE OF WITNESS J. J. Jones		83. SIGNATURE OF DECEASED J. J. Jones		84. SIGNATURE OF WITNESS J. J. Jones	
85. SIGNATURE OF DECEASED J. J. Jones		86. SIGNATURE OF WITNESS J. J. Jones		87. SIGNATURE OF DECEASED J. J. Jones		88. SIGNATURE OF WITNESS J. J. Jones	
89. SIGNATURE OF DECEASED J. J. Jones		90. SIGNATURE OF WITNESS J. J. Jones		91. SIGNATURE OF DECEASED J. J. Jones		92. SIGNATURE OF WITNESS J. J. Jones	
93. SIGNATURE OF DECEASED J. J. Jones		94. SIGNATURE OF WITNESS J. J. Jones		95. SIGNATURE OF DECEASED J. J. Jones		96. SIGNATURE OF WITNESS J. J. Jones	
97. SIGNATURE OF DECEASED J. J. Jones		98. SIGNATURE OF WITNESS J. J. Jones		99. SIGNATURE OF DECEASED J. J. Jones		100. SIGNATURE OF WITNESS J. J. Jones	

BUREAU V. 3

DEC 3 1956

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11904

CERTIFICATE OF DEATH

11888

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>SALISBURY</u>		LENGTH OF STAY (in this place) <u>12 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA General Hospital</u>				STREET ADDRESS (If rural give location) <u>R.E.D.# 3</u>			
3. NAME OF DECEASED (Type or Print) <u>JAMES</u> (First) <u>JACOBS</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 24</u> 19 <u>56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-29-1913</u>	9. AGE last birthday <u>42 yrs.</u>		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>10</u> <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>PEMBROKE, ROBINSON Co. N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ROBERT BRADLEY JACOBS</u>				14. MOTHER'S MAIDEN NAME <u>DAISY LEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>834 GODFREY AVE. MRS. RENA WALLACE, NORFOLK, VA.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
002X IMMEDIATE CAUSE (A) <u>Tubercular Meningitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Tuberculosis possibly lung</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 14</u> , 19 <u>56</u> , to <u>Nov 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 23</u> , 19 <u>56</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Herbert Lemoy</u> M.D.				DATE SIGNED <u>11/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>FAMILY CEMETERY</u>		LOCATION (City, town, or county) (State) <u>PEMBROKE, NORTH CAROLINA</u>	
24. REC'D BY REGISTRAR <u>9 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. F. Stewart</u>		ADDRESS <u>Funeral Home Salisbury, Md.</u>	

CERTIFICATE OF DEATH

Reg. Off. No.

1. USUAL RESIDENCE (NUMBER OR ADDRESS)

1000 ...

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DISPOSITION

BUREAU V. S.

NOV 29 1956

RECEIVED

11905 CERTIFICATE OF DEATH

Reg. Dist. No. 11889 332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 wk.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Rossie Last Johnson				4. DATE OF DEATH Month Nov. Day 19, Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1913	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 43 Days 43 Hours 43 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant		10b. KIND OF BUSINESS OR INDUSTRY State Bd. of Health	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Johnson			
14. MOTHER'S MAIDEN NAME Cora Floyd		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT 212-18-6998	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal stricture 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized carcinomatous DUE TO (c) Gastric carcinoma		INTERVAL BETWEEN ONSET AND DEATH 6 weeks ? 3 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 12, 1956 , to Nov. 19, 1956 , that I last saw the deceased alive on Nov. 19, 1956 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andres Grisolia M.D.				ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 11/19/56	
PHYSICIAN'S NAME (Type) Andres Grisolia, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-56		22c. NAME OF CEMETERY OR CREMATORY Green Acres Cem		22d. LOCATION (City, town, or county) (State) Salisbury Md	
23. FUNERAL DIRECTOR'S SIGNATURE Deer's Head State				ADDRESS		24a. REC'D BY REGISTRAR DATE 11-23-56	
						24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF DECEASED [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
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55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF DECEASED [Illegible]		57. SIGNATURE OF DECEASED [Illegible]	
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64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
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70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
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88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

BUREAU V. S.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11929 CERTIFICATE OF DEATH

11890

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>W.</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1896</u>	9. AGE (In years last birthday) <u>60</u> yns.	IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster Tonger</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John H. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Milenda Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War I</u>				16. SOCIAL SECURITY NO. <u>220-10-9740</u>		17. INFORMANT <u>Sarah Jones, Nanticoke, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>5/15</u> , 19 <u>50</u> , to <u>11/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/21</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Nanticoke, Md</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u> <u>Nanticoke, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick</u> ADDRESS <u>Bivalve, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 30 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>	
5. PLACE OF BIRTH <i>Johns Hopkins</i>		6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1935</i>	
9. PLACE OF DEATH <i>Johns Hopkins</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. DATE OF DEATH <i>Jan 15 1956</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>		31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. 4

NOV 30 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11891

332

260

11906 CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Princess Anne</u> 19X-2 STREET ADDRESS (If rural give location) ✓						
3. NAME OF DECEASED (Type or Print) <u>Wilburne</u> (First) <u>Kelly</u> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>November 1</u> 19 <u>56</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1887 Nov 17</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>EDWARD Kelley</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA SAUNDERS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS <u>W. SAUNDERS, KELLY PRINCEST</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X IMMEDIATE CAUSE (A) <u>Truncular Fibrillation</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Thrombosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____				18. MEDICAL CERTIFICATION <u>Truncular Fibrillation</u> <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Nov 1, 1956</u> to <u>Nov 1, 1956</u> , that I last saw the deceased alive on <u>Nov 1, 1956</u> , and that death occurred at <u>6:48 PM</u> , from the causes and on the date stated above. SIGNATURE <u>G. Herbert Semble</u> M.D. <u>Salisbury MD</u> DATE SIGNED <u>11/2/56</u>								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 8, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Lawn Cemetery Phila.</u>		LOCATION (City, town, or county) <u>Pr.</u>		
24. REC'D BY REGISTRAR DATE <u>Nov 4 56</u>		REGISTRAR'S SIGNATURE <u>Mary H. Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta. Md.</u>		

DEATH CERTIFICATE

NAME OF DECEASED
JAMES A. KELLY

DATE OF DEATH
JANUARY 10, 1956

PLACE OF DEATH
HOSPITAL

NAME OF PHYSICIAN
JAMES A. KELLY

DATE OF DEATH
JANUARY 10, 1956

PLACE OF DEATH
HOSPITAL

BUREAU V. S.

NOV 8 1956

RECEIVED

NOV 10 1956

11907 CERTIFICATE OF DEATH

Reg. Dist. No.

11892337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>304 Buena Vista Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>S.</u> Last <u>Lewis</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/13/1903</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Edith Figgs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. Charles Lewis (304) 420 Hastings St. Salisbury, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> DUE TO 162x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic carcinoma</u> DUE TO (c) <u>-</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>	
21. I certify that I attended the deceased from <u>Oct. 31</u> , 19 <u>56</u> , to <u>Nov. 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 29</u> , 19 <u>56</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andres Grisolia</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>	
DATE SIGNED <u>11/29/56</u>			
PHYSICIAN'S NAME (Type) <u>Andres Grisolia, M. D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 2, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Clive Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Worcester Co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u>	
DATE <u>DEC 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1911		NEW YORK CITY	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JULY 15 1935		NEW YORK CITY		JANE HARRIS		JAN 20 1956		NEW YORK CITY	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CLERK		JAN 15 1935		NEW YORK CITY		JAMES HARRIS		JAN 20 1956		NEW YORK CITY	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JAN 20 1956		NEW YORK CITY		JAMES HARRIS		JAN 20 1956		NEW YORK CITY	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JAN 20 1956		NEW YORK CITY		JAMES HARRIS		JAN 20 1956		NEW YORK CITY	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES HARRIS		JAN 20 1956		NEW YORK CITY		JAMES HARRIS		JAN 20 1956		NEW YORK CITY	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH	
JAMES HARRIS		JAN 20 1956		NEW YORK CITY		JAMES HARRIS		JAN 20 1956		NEW YORK CITY	

BUREAU V. 2

DEC 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11908 CERTIFICATE OF DEATH

11893
Reg. Dist. No.

330

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE COUNTY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENSBORO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENSBORO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEER'S HEAD STATE HOSPITAL</u>		d. STREET ADDRESS <u>SALISBURY, MARYLAND</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT J. LYONS</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 12 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23, 1875</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SAWYER</u>	
11. BIRTHPLACE (State or foreign country) <u>TALBOT COUNTY-MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>WILLIAMS LYONS</u>		14. MOTHER'S MAIDEN NAME <u>WILHELMINA-FRAMPTON-ALICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCL CARDIOVASCULAR DISEASE ?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OSTEOARTHRITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/26/56</u> , 19 <u>56</u> , to <u>11/12/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/12/</u> , 19 <u>56</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. Mullen</u> M.D.			
PHYSICIAN'S NAME (Type) <u>DR. MALDVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>Nov. 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>SPRING HILL</u>		<u>Easton (Rural) Hill in Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam</u>		24a. REC'D BY REGISTRAR DATE <u>19 1956</u>	
ADDRESS <u>Easton Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
CERTIFICATE OF DEATH

RECEIVED
NOV 19 1956
BUREAU A. & B.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11909 **CERTIFICATE OF DEATH**

Reg. Dist. No. 33 ✓

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>DELAWARE</u> COUNTY <u>SUSSEX</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SEAFORD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>GALESTOWN, MARYLAND</u>			
3. NAME OF DECEASED (Type or Print) <u>GLENN</u> (First) <u>MAJORS</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 2 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1-13-1904</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Majors</u>				14. MOTHER'S MAIDEN NAME <u>Iida Mae Floyd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-2197</u>		17. INFORMANT & ADDRESS <u>Elsie Mae Majors - Seaford, Del</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>uremia</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Vascular Disease</u>						<u>underlain</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Coronary artery disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 11:2 A.M., from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>11-2-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-4-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Galestown</u>		LOCATION (City, town, or county) <u>Galestown, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Marnell-Shayton, Jr.</u>		ADDRESS	
DATE <u>NOV 7 1956</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. CAUSE OF DEATH

German speaking
Hypertension vascular disease
4 days

BUREAU V. M.

NO 7 1956

RECEIVED
11-2
J. B. Smith
11-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11895
11910. CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 519 E. Church St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle PAUL Last MARTIN		4. DATE OF DEATH Month NOVEMBER Day 10th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 9 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Engineer) Salisbury Ice Co.		10b. KIND OF BUSINESS OR INDUSTRY Somerset Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Henry Martin		14. MOTHER'S MAIDEN NAME Mary Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-6664	
17. INFORMANT Mrs. Georgia Davis Martin (Wife)		Address 519 E. Church St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH sudden 16 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 10 , 19 56 , to Nov 10 , 19 56 , that I last saw the deceased alive on Nov 2 , 19 56 , and that death occurred at 10:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 334 Camden Ave. Salisbury, Maryland DATE SIGNED Nov. 12 1956			
ACTUAL SIGNATURE William D. Gray M.D.			
PHYSICIAN'S NAME (Type) Dr. William D. Gray M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1956	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR NOV 14 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		45		1911		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		PREVIOUS ILLNESS		CAUSE OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		NONE		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
JAN 15 1956		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		JAN 15 1956		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL SOCIETY		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

JAN 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11911

CERTIFICATE OF DEATH

11896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>POCOMACK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAK HALL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WILLIAM MASON</u>				4. DATE OF DEATH Month Day Year <u>November 30-1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 30-1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER (OWN)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOURENCE D. MASON</u>				14. MOTHER'S MAIDEN NAME <u>HATTIE CLAYTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>230-48-1782</u>		17. INFORMANT Address <u>MRS ETHEL M. MASON, OAK HALL VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 Hrs</u> <u>10 Yrs off.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11-29-1956</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-29</u> , 1956, to <u>11-30</u> , 1956, that I last saw the deceased alive on <u>11-30</u> , 1956, and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>John M. Bloxum III</u> M.D. <u>Salisbury, Md</u>				12-1-1956			
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXUM III</u>				<u>SALISBURY, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 2-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DOWNING ME. CEM</u>		22d. LOCATION (City, town, or county) (State) <u>OAK HALL, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Wagon, Pocomoke</u>				24. REC'D BY REGISTRAR <u>DEC 6 1956</u>		25. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 6 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11930

CERTIFICATE OF DEATH

11897

Reg. Dist. No. 334

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rock-a-walkin</u>		<u>Most of life</u>		TOWN <u>Rural - Hebron</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - Rock-a-walkin</u>				STREET ADDRESS (If rural give location) <u>Route # 2 Box 43</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Louise</u> (Middle) <u>Marie</u> (Last) <u>Morris</u>				(Month) <u>11</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>A.A.</u>	<u>Married</u>	<u>8-29-1910</u>	<u>46</u> yrs.	Months <u>2</u>	Days <u>7</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Housework</u>		<u>Rock-a-walkin, Wicomico Co. Md.</u>		<u>USA</u>	
13. FATHER'S NAME <u>Asbury Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Handy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>720 N. Westover Drive</u> <u>Mrs. Daisy Jones, Salisbury, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442x IMMEDIATE CAUSE (A) <u>Cardiovascular-Renal Disease</u>				<u>6 mo 6 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				<u>Indefinite</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21H. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 May, 1956</u> , to <u>6 Nov, 1956</u> , that I last saw the deceased alive on <u>5 Nov, 1956</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. F. Stewart</u>		ADDRESS (Street, city, town, state) <u>653 W. Main, Salisbury, Maryland</u>		DATE SIGNED <u>9 Nov 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-10-56</u>		<u>Rock-a-walkin Cemetery</u>		<u>Rock-a-walkin, Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>NOV 13 1956</u>		<u>Mary K. Holloway</u>		<u>J. F. Stewart Funeral Home, Salisbury, Md.</u>			

BUREAU V.

NOV 13 1956

RECEIVED

11931 CERTIFICATE OF DEATH

11898 337
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland				c. LENGTH OF STAY IN 1b 46 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Mattie Middle Mumford Last				4. DATE OF DEATH Month Nov. Day 30 Year 19 56			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3. 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace Waters				14. MOTHER'S MAIDEN NAME Harriet Black			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Alta T. Armstrong Fruitland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 30, 1956 to Nov 30, 1956 , that I last saw the deceased alive on 30 Nov 56 , 19____, and that death occurred at 1:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. A. Furnell				M.D. 652 W. Main Salisbury Md			
PHYSICIAN'S NAME (Type) E. A. Furnell, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-4-1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Oliver Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lewis B. Wilson				ADDRESS Princess Anne, Md		24a. REC'D BY REGISTRAR DATE 6 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Hollaway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

DEC 6 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11912 CERTIFICATE OF DEATH

11899

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Santatarium		d. STREET ADDRESS Crisfield 19-39-2	
3. NAME OF DECEASED (Type or print) First DOLLY Middle M. Last NAILOR		4. DATE OF DEATH Month November Day 6 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jessie Byrd		14. MOTHER'S MAIDEN NAME Jennie Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 222-18-3543	
17. INFORMANT Arthur H. Nelson-512 Buena Vista Ave.-Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Bladder DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/14/52 , 19____, to Nov 5 , 19____, that I last saw the deceased alive on Nov 5 , 19____, and that death occurred at 1:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE L. R. Granger M.D. Salisbury, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR DATE 11-22-56	
24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

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BUREAU V. 3

NOV 26 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11913 CERTIFICATE OF DEATH

11900

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>md</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS (If rural give location)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS (If rural give location)	
TOWN <i>Salisbury</i>				TOWN <i>Regel Oak Md.</i>		STREET ADDRESS <i>Regel Oak -</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Pen Sen Hospital</i>							
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <i>Marjabelle</i>		(Middle) <i>Norman</i>		(Last) <i>Norman</i>		(Date) <i>11 17 1956</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>C</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>		8. DATE OF BIRTH <i>June 15, 1942</i>	
9. AGE last birthday <i>14 yrs.</i>		10. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>Willie Norman</i>				14. MOTHER'S MAIDEN NAME <i>Maime Chesson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>(If Yes, give war or dates of service)</i>				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <i>Willie Norman</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
202.1 IMMEDIATE CAUSE (A) <i>Asphyxia</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Tracheal obstruction</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Mediastinal lymphoma</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.							
SIGNATURE <i>Eugene J. Linberg</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury Md.</i>		DATE SIGNED <i>11-17-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>11-20-56</i>		NAME OF CEMETERY OR CREMATORY <i>Shilo Cem</i>		LOCATION (City, town, or county) (State) <i>Regel N.C.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks M. Coet.</i>		ADDRESS	
DATE <i>11-23-56</i>							

BUREAU V. S.

NOV 26 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11914 CERTIFICATE OF DEATH

Reg. Dist. No. 11901

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oklahoma b. COUNTY Kiowa			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 26 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1010 S. Division, Street.				d. STREET ADDRESS Route # 1.			
3. NAME OF DECEASED (Type or print) First John Middle D. Last Presley				4. DATE OF DEATH Month Nov. Day 14. Year 56.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 4, 1877.		9. AGE (In years birthday) yrs. 79	IF UNDER 1 YEAR Months 8 Days 10	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rural Carrier			10b. KIND OF BUSINESS OR INDUSTRY U. S. Mail.		11. BIRTHPLACE (State or foreign country) Mountain View, Oklahoma.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joel Presley				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Anna S. Presley (Wife) Address R.D.# 1.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative heart failure 422.2 DUE TO Degenerative heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mountain View, Oklahoma.							INTERVAL BETWEEN ONSET AND DEATH 1 year.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11/13 , 19 56 , to 11/13 , 19 56 , that I last saw the deceased alive on 11/13 , 19 56 , and that death occurred at 2.25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11/14/56 ACTUAL SIGNATURE E.M. Beardsley M.D. _____ PHYSICIAN'S NAME (Type) E.M. Beardsley 207 Maryland Ave. Salisbury, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20, 56.		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery.		22d. LOCATION (City, town, or county) _____ (State) _____ Mountain View, Oklahoma.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co.				ADDRESS Salisbury, Maryland.		24a. REC'D BY REGISTRAR NOV 16 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 16 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

119'5 CERTIFICATE OF DEATH

11902

Reg. Dist. No. 932

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Delmar</u>		46X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>203 N. Second</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SUSSAN</u>		(Middle) <u>FAY</u>		(Last) <u>Rayne</u>		(Month) <u>November</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Never</u>	8. DATE OF BIRTH <u>11-16-1936</u>	9. AGE last birthday yrs.		IF UNDER 1 YEAR (Months) <u>1</u> (Days) <u>1</u> IF UNDER 24 HRS. (Hours) <u>1</u> (Min.) <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Rayne</u>				14. MOTHER'S MAIDEN NAME <u>Berbara Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Charles Rayne - Delmar Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
760.5 IMMEDIATE CAUSE (A) <u>Intracranial Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ventricular and Subdural</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>? Bradycardia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Immaturity (3 lbs - 9 oz)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, term, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 17 56</u> to <u>Nov 17 56</u> , that I last saw the deceased alive on <u>Nov 17 56</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. J. Summerville</u>		DATE THEREOF <u>11-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		LOCATION (City, town, or county) (State) <u>Delmar Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mary Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Sparr</u>		ADDRESS <u>Co - Delmar, Md</u>	

2082213XV21

CERTIFICATE OF DEATH

Form No. 1

1. REGISTRATION NUMBER OR DISTRICT

MARYLAND

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

DATE OF DEATH

1. MEDICAL CERTIFICATION

1. MEDICAL CERTIFICATION

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INSTRUCTIONS

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13072

336

CERTIFICATE OF DEATH

11932

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Wicomico</u> <u>md</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salmon</u> TOWN <u>Salmon</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salmon</u> OR TOWN <u>Salmon</u> STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) <u>Della</u> (First) <u>Reid</u> (Middle) <u>Reid</u> (Last)				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 11 - 06</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willie Cuff</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-16-7033</u>		17. INFORMANT & ADDRESS <u>Cecilia Reid</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>151X IMMEDIATE CAUSE (A) Cancer of stomach</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>ANTECEDENT CAUSE(S) DUE TO (B) pulmonary tuberculosis</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arterio-sclerotic heart disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-20, 1956</u> , to <u>11-25, 1956</u> , that I last saw the deceased alive on <u>11-20, 1956</u> , and that death occurred at <u>12:30</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salmon, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-26-56</u>	NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cem</u>		LOCATION (City, town, or county) (State) <u>Salisbury md</u>		
24. REC'D BY REGISTRAR <u>DEC 26 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS	
DATE							

CERTIFICATE OF DEATH

Top Part No.

1. LOCAL RESIDENT HOME

MARYLAND

COUNTY OF

CITY OF

WARD OF

STREET

APARTMENT

ROOM

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

RECORDED

BUREAU V. S.

DEC 29 1956

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11903

11916 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital(D.O.A.)				d. STREET ADDRESS R.F.D.			
3. NAME OF DECEASED (Type or print) HARROD WINFIELD ROBERTSON				4. DATE OF DEATH Month 11 Day 23 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1914	
9. AGE (In years last birthday) 42 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Traffic Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Gas Pumps		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George W. Robertson			
14. MOTHER'S MAIDEN NAME Bertie Wainwright				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) A.T.C. II			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Kathleen W. Robertson, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstruction of Coronary Artery 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH minutes years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 23, 1956 , to Nov. 23, 1956 , that I last saw the deceased alive on Nov. 23, 1956 , and that death occurred at 6:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Kendrick W. McCallough M.D.				ADDRESS (Street, city or town, state) 20123, Md. DATE SIGNED Nov. 23, 1956			
PHYSICIAN'S NAME (Type) Kendrick McCallough				acting deputy medical examiner for Wicomico County			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		11/25/56		Rockwalkin Cemetery		Rockwalkin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE 11-24-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway <i>per J.P.</i>	

Norman T. Baker

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

RECEIVED
 NOV 28 1956
 BUREAU V. 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11933 CERTIFICATE OF DEATH

11904

Reg. Dist. No.

232

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walnut St		d. STREET ADDRESS Watnut St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEANDER Middle FRANKLIN Last SHOCKLEY		4. DATE OF DEATH Month NOVEMBER Day 10th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1871
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 15 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Worcester Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John H. Shockley		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Dickerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Address Mrs. Mary E. Shockley (Wife) Walnut St. Hebron, Md.		Mrs. Augusta Phillips (Daughter) Walnut St-Hebron, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 coronary Heart Disease DUE TO failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/9 , 19 56 , to Nov 10 , 19 56 , that I last saw the deceased alive on 11/9 , 19 56 , and that death occurred at 12:30 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Grove St. Delmar, Delaware		DATE SIGNED Nov. 10 1956	
ACTUAL SIGNATURE Ernest M. Larmore M.D.			
PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore M.D.		Delmar, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 12, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR NOV 14 1956 DATE	
		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 14 1956

RECEIVED

11934 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>602 E. State Street</u>	
3. NAME OF DECEASED (Type or print) <u>Edwin</u> First <u>Thomas</u> Middle <u>Sirmon</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>23</u> Day <u>1956</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1974</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penon. Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William L. Sirmon</u>		14. MOTHER'S MAIDEN NAME <u>M. E. Augusta Gordy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-03-2885</u>	
17. INFORMANT <u>Paul Fitzgerald</u> Address <u>Delmar, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1956</u> , to <u>Nov 23, 1956</u> , that I last saw the deceased alive on <u>May 1956</u> , and that death occurred at <u>10:10</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. V. Sokler</u> M.D.		ADDRESS (Street, city or town, state) <u>323 East Street, Delmar, Md.</u> DATE SIGNED <u>Nov 27 1956</u>	
PHYSICIAN'S NAME (Type) <u>L. V. Sokler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/25/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Delmar</u>	22d. LOCATION (City, town, or county) (State) <u>Del</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Marvello</u> ADDRESS <u>Delmar, Del.</u>		24a. REC'D BY REGISTRAR <u>Nov 27 1956</u>	24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME JOHN J. ROBERTS		DATE OF DEATH 10-10-1956	
AGE 45		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
BIRTH DATE 10-10-1911		BIRTH PLACE NEW YORK, N.Y.	
MARRIAGE MARRIED		SPOUSE'S NAME MARY J. ROBERTS	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH HOME		DATE OF BURIAL 10-12-1956	
BURIAL PLACE CATHOLIC CEMETERY		SIGNATURE OF DECEASED [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF REGISTRAR [Signature]	

BUREAU V. 1

NOV 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11917 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11906
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
c. LENGTH OF STAY IN 1b <u>18 days</u>		d. STREET ADDRESS <u>23-42-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Braxton</u> <u>Smith</u>		4. DATE OF DEATH Month Day Year <u>11</u> <u>4</u> <u>19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1938</u>
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>18</u> <u>18</u> <u>18</u> <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Hortense Trader</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>John Smith</u>		Address <u>Pocomoke, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Third degree burns of entire head, arms, legs, hands.</u> (c) <u>18 days</u> DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned when involved in a two car collision.</u>	
20c. TIME OF INJURY Hour <u>7:30</u> a. m. <u>p. m.</u> Month, Day, Year <u>10-17-1956</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Princess Anne Somerset Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-6-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-7-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>First Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Mappsville, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		ADDRESS <u>New Church, Va.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11-10-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> <u>per J. F. P.</u>	

STATE OF MARYLAND—Baltimore
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIED		SINGLE		WIDOWED	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		INJURY		POISON		OTHER	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		STATE	

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 NOV 16 1956
 BUREAU V. S.

119'8

CERTIFICATE OF DEATH

11907

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen/ Hospital				d. STREET ADDRESS 212 West Locust St			
3. NAME OF DECEASED (Type or print) First WALTER Middle HARVEY Last SMITH				4. DATE OF DEATH Month NOVEMBER Day 5 th 19 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 5 Days 21	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Laborer of			10b. KIND OF BUSINESS OR INDUSTRY Manhattan Shirt Co		11. BIRTHPLACE (State or foreign country) Greensboro, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Robert Smith				14. MOTHER'S MAIDEN NAME Rachel Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Florence Smith (Wife) Address 212 West Locust St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PROLONGED SHOCK DUE TO (c) BLEEDING DUODENAL ULCER							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 NOV 1956 to 5 NOV 1956 , that I last saw the deceased alive on 5 NOV 1956 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE EJ Linberg				ADDRESS (Street, city or town, state) Medical Center		DATE SIGNED Nov. 6 1956	
PHYSICIAN'S NAME (Type) Dr. E. J. Linberg M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Line Church Cemetery		22d. LOCATION (City, town, or county) (State) Near-Whitesville, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME -- SALISBURY, MD.				ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR NOV 7 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

BUREAU V. 5

956T. 4 AU

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11908

11935 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>Md</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Belmar</i>		TOWN <i>Belmar Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
3. NAME OF DECEASED (Type or Print) <i>Bettie</i> (First) <i>Stewart</i> (Last)				4. DATE OF DEATH (Month) <i>11</i> (Day) <i>18</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Coe</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Wid</i>	8. DATE OF BIRTH <i>4-27-1882</i>	9. AGE last birthday <i>74</i> yrs.	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i>	IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Salisbury Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Geo. Williams</i>				14. MOTHER'S MAIDEN NAME <i>Emeline Lewis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Sarora Stewart</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <i>arteriosclerotic heart disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>with failure</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>(nos. - contributory) (cardiac carcinoma) (exacerbated) (myocardial infarction)</i>				<i>6 mos</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/11/56, 1956, to death, 11/17/56, 1956, that I last saw the deceased alive on 11/17/56, 1956, and that death occurred at 8:40 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Ernest Larson</i> M.D.				ADDRESS (Street, city, town, state) <i>Belmar Bel Md</i>		DATE SIGNED <i>11/19/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>11-21-56</i>	NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem</i>		LOCATION (City, town, or county) <i>Belmar Md</i>			
24. REC'D BY REGISTRAR <i>11-23-56</i>	REGISTRAR'S SIGNATURE <i>Mary W. Helweg</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks M. West</i>		ADDRESS		

NOV 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11919 CERTIFICATE OF DEATH

1190937

Reg. Dist. No. 62

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB <u>3 wks</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Spring Hill Nursing Home</u>		d. STREET ADDRESS <u>Denton</u>	
3. NAME OF DECEASED (Type or print) <u>ELLA</u> First Middle Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21, 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Eaton</u>		14. MOTHER'S MAIDEN NAME <u>Anna Master</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>William Stockley, Denton, Ind.</u>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generally old cardiovascular</u> 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestion of heart</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 12, 1956</u> to <u>Nov 2, 1956</u> that I last saw the deceased alive on <u>Nov 2, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Philip A Insley</u> M.D.		PHYSICIAN'S NAME (Type) <u>Philip A Insley</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 3, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Croome</u>	22d. LOCATION (City, town, or county) (State) <u>Indian Creek, Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Vayd Monahan, Denton</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>11/13/56</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. H. Holloway</u>

1891

11936

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1 (Shad Point)				d. STREET ADDRESS R.D.# 1 (Shad Point)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle BRINKLEY Last TOWNSEND				4. DATE OF DEATH Month NOVEMBER Day 16th Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Siloam Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Townsend				14. MOTHER'S MAIDEN NAME Lorraine Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Corbett C. Townsend (Son) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) years DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 17 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery		22d. LOCATION (City, town, or county) (State) Siloam, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD				24a. REC'D BY REGISTRAR DATE 19 1956		24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11920

CERTIFICATE OF DEATH

11911

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				c. LENGTH OF STAY IN 1b <i>3 weeks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Riverside Nursing Home</i>				d. STREET ADDRESS <i>Rural #2</i>			
3. NAME OF DECEASED (Type or print) <i>S. CLYDE TOWNSEND</i>				4. DATE OF DEATH <i>November 14 1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 10 1876</i>	9. AGE (In years last birthday) <i>80</i>	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer (own)</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Sidney Townsend</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Trader</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-16-7984</i>			
17. INFORMANT <i>William S. Townsend</i>				Address <i>(Pocomoke and)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral arteriosclerosis</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>12-30, 1956</i> to <i>11-14, 1956</i> that I last saw the deceased alive on <i>11-14, 1956</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Salisbury, MD</i> DATE SIGNED <i>11-16-56</i>							
ACTUAL SIGNATURE <i>William S. Townsend</i>				M.D. <i>Salisbury, MD</i>			
PHYSICIAN'S NAME (Type) <i>William S. Townsend</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 17-1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St John's M.E. Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Fruitland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry A. Watson</i>				ADDRESS <i>Pocomoke Md.</i>		24a. REC'D BY REGISTRAR <i>Mary H. Holloway</i>	
				DATE <i>19 1956</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 19

1956

BUREAU V. 3

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11912

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 0		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Pen. Gen. Hospital				d. STREET ADDRESS R.D. # 1 (Shad Point)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HAROLD Last TOWNSEND				4. DATE OF DEATH Month NOV. Day 23rd Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15th 1899	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 11 Days 8	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Laborer) Wayne Pump Co.		10b. KIND OF BUSINESS OR INDUSTRY Wayne Pump Co.		11. BIRTHPLACE (State or foreign country) Shad Point, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Littleton M. Townsend				14. MOTHER'S MAIDEN NAME Ida Belle Malone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Lenora Jones Townsend (Wife) R.D. # 1 (Shad Point) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 occlusion of coronary artery DUE TO (b) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 260x DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 25, 1956		22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery	
22d. LOCATION (City, town, or county) (State) R.D. # 1 Salisbury, Md. (Shad Point)							
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR NOV 26 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 26 1956

RECEIVED

11937 CERTIFICATE OF DEATH

Reg. Dist. No.

11913

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Willards		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) Maggie Ann Tubbs		4. DATE OF DEATH Nov. 12 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1867 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME E. Myer Truitt		14. MOTHER'S MAIDEN NAME Eliza Truitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X (If yes, give war and dates of service) X		16. SOCIAL SECURITY NO. X	
17. INFORMANT Mrs. Margie Wilkins		Address Willards, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative myocarditis, c. Anasarka 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis + Senility DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 1950, to Nov 12 , 1956, that I last saw the deceased alive on Nov 11 , 1956, and that death occurred at 12:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Heaman A. Rablun M.D.		ADDRESS (Street, city or town, state) Berlin, Md.	
DATE SIGNED 11/12/56			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/14/56	22c. NAME OF CEMETERY OR CREMATORY New Hope	22d. LOCATION (City, town, or county) (State) Willards, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		24a. REC'D BY REGISTRAR Nov 14 1956	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1956 14 NOV

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may be retained by the hospital or attending physician. In by the funeral director, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11922 CERTIFICATE OF DEATH

11914 3 32
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 30 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		d. STREET ADDRESS --	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Tyler		4. DATE OF DEATH Month Nov. Day 28 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1912
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Queen Anne's County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Tyler		14. MOTHER'S MAIDEN NAME Bessie Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 165-14-0442	
17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 26 days 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 29, 1956 , to Nov. 28, 1956 , that I last saw the deceased alive on Nov. 28, 1956 , and that death occurred at 2 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andres Grisolia		ADDRESS (Street, city or town, state) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Andres Grisolia		DATE SIGNED 11/28/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1	
22c. NAME OF CEMETERY OR CREMATORY Centreville		22d. LOCATION (City, town, or county) (State) Centreville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edward A. Rane		ADDRESS Church Hill, d.	
24a. REC'D BY REGISTRAR DEC 3 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES H. HARRIS		Male		45		1910		Maryland		1956		Baltimore		Heart Disease		Natural		J. H. Harris		J. H. Harris		1956	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Country		19. Date of registration		20. Signature of registrar		21. Date of registration		22. Signature of registrar		23. Date of registration		24. Signature of registrar	
J. H. Harris		Son		1234 Main St.		Baltimore		Maryland		USA		1956		J. H. Harris		1956		J. H. Harris		1956		J. H. Harris	

BUREAU V. 2

DEC 3 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11938

CERTIFICATE OF DEATH

Reg. Dist. No.

11915
29

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mardela		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2 Delmar Delaware		d. STREET ADDRESS R.D.# 2 Delmar Delaware	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAUDE BLANCHE WRIGHT		4. DATE OF DEATH Month November Day 30th Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1886
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Mardela, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Levin R. Wilson		14. MOTHER'S MAIDEN NAME P. Cora Sheppard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. Charles M. Wright (Husband) Address R.D.#2 (Delmar, Del.) Mardela, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/9/56 , 19____, to 11/30/56 , 19____, that I last saw the deceased alive on 11/30/56 , 19____, and that death occurred at 3:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred R. Gramse		M.D. S/Division St. (Office) Nov. 30, 1956	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 2, 1956	
22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DEC 3 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. SIGNATURE OF DECEASED [Faint text]</p>	
<p>10. SIGNATURE OF WITNESS [Faint text]</p>		<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF CORONER [Faint text]</p>	
<p>13. SIGNATURE OF JURY [Faint text]</p>		<p>14. SIGNATURE OF JUDGE [Faint text]</p>		<p>15. SIGNATURE OF CLERK [Faint text]</p>	

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6208 12-17-56 et

11939

CERTIFICATE OF DEATH

Reg. Dist. No.

13086 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Carrie Zimmerman		4. DATE OF DEATH November 25 19 56	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/56 1868
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Days 1 Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Nanticoke, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alexander Franklin Turner		14. MOTHER'S MAIDEN NAME Sarah R. Willing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Amy F. Messick, Bivalve, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Dec , 19 56 , to 28 Nov , 19 56 , that I last saw the deceased alive on 28 Nov , 19 56 , and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard H. Saunders M.D.		ADDRESS (Street, city or town, state) Nanticoke Md.	
DATE SIGNED 11/30/56			
PHYSICIAN'S NAME (Type) Richard H. Saunders		Nanticoke, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/56	
22c. NAME OF CEMETERY OR CREMATORY Turner's Cem.		22d. LOCATION (City, town, or county) (State) Nanticoke Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Messick ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR DEC 10 1956 DATE 11/30/56	
		24b. REGISTRAR'S SIGNATURE Mary Holloway	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Date of Registration	
Alexander John Thomas		Male		White		10/25/1915		11/15/1956		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]		12/10/1956	
13. Name of Informant		14. Relationship		15. Address		16. Telephone		17. Signature of Informant		18. Signature of Registrar		19. Date of Registration		20. Date of Death		21. Date of Birth		22. Date of Death		23. Date of Birth		24. Date of Death	
John Thomas		Son		1234 Main St.		123-4567		[Signature]		[Signature]		12/10/1956		11/15/1956		10/25/1915		11/15/1956		10/25/1915		11/15/1956	

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DEC 10 1956

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